

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/27/2011
NAME OF PROVIDER OR SUPPLIER SMITH COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 112 HEALTH CARE DR CARTHAGE, TN 37030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual Recertification survey and complaint investigations #27146, 27625, 27754, 27932, 28322, and 28435 were completed at Smith County Health Care Center on July 25 - 27, 2011. Deficiencies were cited on complaint investigation #27146. No deficiencies were cited for complaint #27625, 27754, 27932, 28322, and 28435 under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.		
F 226 SS=D	483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to implement the abuse policy for one (#15) of twenty-nine residents reviewed. The findings included: Resident #15 was admitted to the facility on July 8, 2010, and readmitted on March 28, 2011, with diagnoses including Chronic Obstructive Pulmonary Disease, Intractable Back Pain, Diabetes, Bipolar Disorder, and Depression with Psychotic Features. Review of an investigation provided by the facility revealed "on Sat 11/06/10 at 4:00 p.m., (approximate) CNT (Certified Nursing	F 226	F226 The facility has written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property that are implemented. The Resident identified as resident #15. No harm was noted to resident #15. No other residents were found to be affected. Residents most at risk of abuse may include but is not limited to residents who have dementia, residents with no or infrequent visitors, residents with psychosocial and/or behavior issues and residents who are bedfast and totally dependent on care. The Administrator, DON, ADON and Licensed Nursing Supervisors will receive education by the SDC on the Center Abuse Policies. (09/09/11) In any instance of alleged abuse the employee will be suspended from work until the investigation is complete. This action per Center Policy. Abuse Education is accomplished in Employee Orientation, Employee Annual Inservice Education and semi-annually through staff inservice education. Any future allegations of abuse and its investigation with results will be reviewed and reported to the PI Committee monthly for 6 months and until investigation reports are found to meet policy.		09/09/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	<p>Continued From page 1</p> <p>Technician/CNA) (CNA #1) was noticed to be in a verbal 'argument' with a resident (#15) in which (CNA #1) said 'Rot in hell for all I care.' This incident was witnessed by another (CNA #2) and reported to the Shift Nursing Supervisor. The RN (Registered Nurse #1) Supervisor notified the Director of Nursing and the Administrator. (RN #1) indicated the resident was eating, smiling and happy with no complaints when (RN #1) visited...In (the resident's) room after incident. (CNA #1) was removed from caring for this resident and told to report to the administrator Monday 11/08/10..."</p> <p>Interview on July 26, 2011, at 10:55 a.m., with CNA #2, in the Administrator's office, revealed CNA #2 was present with CNA #1 on November 6, 2010, at the time of the incident. Continued interview with CNA #2 revealed CNA #2 was familiar with the resident and CNA #1. Continued interview revealed resident #15 accused CNA #1 of not looking for (the resident's) glasses and CNA #1 had replied "You can rot in hell before I do anything for you."</p> <p>Review of a statement signed by CNA #1 revealed "on Sat 11-6-10 I went into (resident #15's room) and answered the call light it was (resident #15). (resident #15) accused me of stealing...eye glasses, I told...if I found them then I would bring them to (the resident). (The resident) said 'All I was going to do was hide under...bed and throw them back up at (the resident) when...fell asleep so that way I make (the resident) think...has lost...mind.' I stated that (the resident) can rot in hell for all I care. Then I went and told (RN #1) what had happen."</p>	F 226	<p>The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).</p> <p>The Administrator is responsible for overall compliance.</p>		

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F 226	<p>Continued From page 2</p> <p>Telephone interview on July 27, 2011, at 8:45 a.m., with Registered Nurse (RN) #1 (supervisor at the time of the incident), confirmed there was an allegation of verbal abuse to resident #15 by CNA #1 on November 6, 2010. Continued interview revealed RN #1 had checked on resident #15, on November 6, 2010, after the allegation of abuse, and had asked the resident if...was alright, and the resident did not know why was asked this question. Continued interview revealed the resident was hard of hearing and probably had not heard what CNA #1 had said. Continued interview revealed RN #1 had notified the Administrator of the allegation on November 6, 2010, and was instructed to not allow CNA #1 to enter resident #15's room. Continued interview revealed CNA #1 was allowed to continue providing care to other residents after the allegation of verbal abuse.</p> <p>Review of the facility's policy Protection of Resident During An Investigation revealed "...A staff member(s) implicated in an abuse/neglect situation...will be immediately removed from any resident contact..."</p> <p>Observation on July 26, 2011, at 3:05 p.m., revealed resident #15 lying on the bed watching television. Interview with resident #15, at the time of the observation, revealed the resident denied being verbally or physically abused while a resident at the facility.</p> <p>Interview on July 27, 2011, at 9:35 a.m., with the Administrator, in the Administrator's office, revealed CNA #1 was removed from providing care to resident #15 on November 6, 2010, after the allegation of verbal abuse. Continued</p>	F 226			

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F 226	Continued From page 3 interview revealed CNA #1 continued to care for other residents on November 6, 2010, until the end of the shift at 10:00 p.m. Continued interview confirmed CNA #1 was not immediately removed from resident contact, after the allegation of verbal abuse, and confirmed the facility's policy was not followed.	F 226			
F 281 SS=D	c/o #27146 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to follow a physician's order for medication administration for one resident (#16) of twenty nine-residents reviewed. The findings included: Resident #16 was admitted to the facility on September 22, 2009, with diagnoses of Altered Mental Status, Hydronephrosis, Psychosis, and alteration of Gait. Medical record review of the Resident Progress Notes, dated May 23-July 15, 2011, revealed confusion, inappropriate comments and gestures by the resident toward the staff, calling nurses "... Stupid and worthless...", and "...throwing Seroquel (antipsychotic) and Potassium (electrolyte replacement) in the trash can..."	F 281	F281 The Resident found to be affected was identified as resident #16. No harm was noted to resident #16. No other residents were found to be affected. Medication was administered to resident #16 on 07-27-11. The attending Physician was notified of omission 07-27-11. Residents who may be affected by this deficient practice are all residents in the Center. The ID Team consisting of Director of nursing, Assistant Director of Nursing, Staff Development Director, Unit Coordinator, MDS Coordinator and Social Services Director to audit all in house residents Medication record to ensure no omissions. Corrective action will be taken on any omissions. Director of Nursing to council Licensed Nurse who created this medication omission. This nurse to receive inservice by the SDC. The Staff Development Coordinator to inservice Licensed Nurses on Medication administration and documentation. 09/09/11) Licensed Personnel are instructed in Orientation and through annual competency reviews to meet professional standards in medication administration.	09/09/11	

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F 281	<p>Continued From page 4</p> <p>Medical record review revealed a physician's order, dated July 22, 2011, for Haldol Decanoate (antipsychotic) 100mg/ml (milligrams/milliliters) IM (intramuscular) 200mg/ml monthly.</p> <p>Medical record review of the MAR (Medication Administration Record) for July 2011, revealed an order for "Haldol Decanoate 100mg/ml IM 200mg (2ml) monthly" written on July 22, 2011. Review of the MAR revealed the administration date on the MAR was July 22, 2011, and not signed off on the MAR to confirm the resident had received the medication as ordered.</p> <p>Observation on July 26, 2011, at 2:10 p.m., in the resident's room, revealed the resident lying on the bed, using the call light numerous times. Observation revealed when staff entered the room the resident asked "turn the lights off over the bed" and became argumentative with staff over "unlocking the bed".</p> <p>Observation on July 27, 2011, at 8:20 a.m., revealed the resident was confused and yelling at the staff.</p> <p>Interview with LPN #1, on July 27, 2011, at 8:20 a.m., in the hallway outside of the residents room, confirmed the medication was not signed off as given, the medication was in the medication cart drawer, and the medication had not been given as ordered.</p> <p>Interview with the Director of Nursing on July 27, 2011, at 8:30 a.m., in the medication room, confirmed the medication had not been administered as ordered.</p>	F 281	<p>The ID Team, DON consisting of Director of nursing, Assistant Director of Nursing, Staff Development Director, Unit Coordinator, MDS Coordinator and Social Services Director to audit 10% of in house residents Medication records monthly X 3 months, then quarterly to ensure medication administration.</p> <p>Results to be reported to Performance Improvement Committee monthly to ensure compliance.</p> <p>The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).</p> <p>The Administrator is responsible for overall compliance.</p>		

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F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview the facility failed to develop an appropriate bladder training program for two (#19, #12) of twenty-nine residents reviewed.</p> <p>The findings included:</p> <p>Medical record review revealed resident #19 was admitted to the facility on June 9, 2008, with diagnoses to include Dementia, Acute Renal Failure, Diabetes Mellitus, Hypertension, and Degenerative Joint Disease.</p> <p>Review of the MDS (Minimal Data Set) dated June 2011, revealed the resident was incontinent of bladder on a daily basis.</p> <p>Medical record review of a report from the Urology Consultants dated June 21, 2011, revealed "... bladder incontinence. Continue with bowel and bladder program. Prompt to void. Has</p>	F 315	<p>F315</p> <p>The facility has in place a bowel and bladder program.</p> <p>The Residents found to be affected was identified as resident #19 and resident #12. No harm was noted to resident #19 or #12. Residents #12 and #19 assessed to determine a new voiding pattern .08/09/11. An individualized bladder program to be established for resident #19 and resident #12.</p> <p>All residents have the potential to be affected by this deficient practice. Director of Nursing, Staff Development Coordinator to inservice the restorative nurse on the Bowel and Bladder evaluation and process. (09/09/11)</p> <p>Director of Nursing, Staff Development Coordinator and Restorative Nurse to inservice the restorative CNT's and staff CNT's on the Bowel and Bladder evaluation and process. (09/09/11)</p> <p>Current residents to be screened to determine potential for participation in the Bowel and Bladder Program by the Restorative Nurse. (09/09/11)</p> <p>New admissions to be screened by the ID Team consisting of Director of nursing, Assistant Director of Nursing, Staff Development Director, Unit Coordinator, MDS Coordinator and Social Services Director through the Care Plan Process determine potential for participation in the Bowel and Bladder Program.</p>	09/09/11	

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F 315	<p>Continued From page 6</p> <p>functional and urge incontinence as well as detrusor (bladder muscle) instability".</p> <p>Continued medical record review of Flow Sheets for May 2011 revealed the resident was incontinent of urine and was totally dependent for toileting and required one person assist. Further medical record review revealed no evidence the 72 hour voiding pattern had been completed. Continued medical record review revealed no evidence of a bladder training program in place.</p> <p>Interview on July 26, 2011, at 3:15 p.m., in the nurses' station, the Director of Nursing confirmed no evidence of a 72 hour voiding pattern or the resident was on a bladder training program.</p> <p>Interview on July 26, 2011, at 3:30 p.m., in the nurses' station, Registered Nurse (RN) #3 stated the resident is taken to the bathroom every two hours and whenever the resident asks to go to the bathroom. Continued interview revealed RN #3 confirmed a 72 hour voiding pattern had not been completed on the resident. Further interview revealed the Certified Nursing Assistants take the resident to the bathroom every two hours but often the resident is incontinent before reaching the bathroom so was marked as incontinent for a whole month on the Flow Record. Continued interview with RN #3 revealed no bladder training program was in effect for this resident.</p> <p>Resident #12 was admitted to the facility on April 5, 2011, with diagnoses including Chronic Obstructive Pulmonary Disease, Fracture Left Forearm, Hypertension, and Congestive Heart Failure.</p>	F 315	<p>To assure compliance 10% of in house residents medical records to be audited monthly for 3 months and quarterly thereafter by the Restorative Nurse. Results to be reported to Performance Improvement Committee monthly to ensure compliance. The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s). The Administrator is responsible for overall compliance.</p>		

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F 315	<p>Continued From page 7</p> <p>Medical record review of the Minimum Data Set (MDS) dated April 5, 2011, revealed the resident was continent of bladder. Medical record review of the MDS dated June 23, 2011, revealed the resident was occasionally incontinent of bladder.</p> <p>Medical record review of the Bladder Voiding Pattern Record dated May 25, 26, and 27, 2011, revealed the only times the resident was incontinent was on the 2:00 p.m., until 10:00 p.m., shift (a total of seven times).</p> <p>Medical record review revealed no documentation an individualized toileting plan was developed for the resident.</p> <p>Review of the facility's policy Bladder Status Evaluation revealed "A bladder status evaluation is performed on residents identified as incontinent...When completing the comprehensive assessment, consider the following...Voiding patterns...nighttime or daytime...Develop treatment/retraining interventions tailored to the resident's needs..."</p> <p>Observation on July 26, 2011, at 7:40 a.m., revealed the resident lying on the bed, with the head of the bed elevated, eating breakfast.</p> <p>Interview on July 25, 2011, at 2:00 p.m., with Licensed Practical Nurse (LPN) #3, at the nursing station, revealed the resident, and all residents, were to be toileted every two hours.</p> <p>Interview on July 25, 2011, at 2:10 p.m., with the Director of Nursing, at the nursing station, confirmed an individualized toileting plan was not implemented for the resident.</p>	F 315			

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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure safety measures were in place or functional for one (#10) of twenty-nine residents reviewed.</p> <p>The findings included:</p> <p>Resident #10 was admitted to the facility on August 11, 2009, with diagnoses including Alzheimer's Dementia with Delusions, Atrial Fibrillation, Depression, and Hypertension.</p> <p>Medical record review of the Minimum Data Set dated May 10, 2011, revealed the resident had severely impaired cognitive skills, required limited assistance with transfers/ambulation, and had experienced a fall.</p> <p>Medical record review of the Fall Risk Assessment dated February 15, 2011, revealed the resident was at high risk for falls.</p> <p>Medical record review of the Comprehensive Care Plan Report dated February 1, 2011, revealed "...Falls/Injury, risk...Bathroom door</p>	F 323	<p>F323 It is the practice of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. Resident #10 sustained no adverse affects from this deficient practice. Actions were taken at the time of the falls to re-educate staff to gait belt usage and the alarm battery was replaced.</p> <p>All residents with a fall potential have the potential to be affected by this deficient practice.</p> <p>ID Team consisting of Director of Nursing, Assistant Director of Nursing, Staff Development Director, Unit Coordinator, MDS Coordinator and Social Services Director to audit all in house residents medical records to ensure safety interventions are in place for residents at risk for falls. The audit will include residents that require gait belt usage and presence of bathroom alarms. 09/09/11.</p> <p>Staff Development Coordinator to in service Licensed Nurses and CNT's to gait belt usage, usage of door alarms. 09/09/11.</p> <p>CNT personnel expected to have gait belts with them at all times while on the floor. Central Supply Clerk to monitor/change batteries in all patient bathroom door alarms on a designated day each week. This monitoring will be established to include all alarms with batteries.</p> <p>Monitoring by the DON and ADON.</p>	09/09/11	

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07/27/2011

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STREET ADDRESS, CITY, STATE, ZIP CODE

112 HEALTH CARE DR

CARTHAGE, TN 37030

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F 323

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alarm on at all times...Transfers with assist of (1) with a gait belt..."

Medical record review of the nursing notes dated March 9, 2011, at 6:10 p.m., revealed "Called to resident room by CNT (Certified Nursing Assistant). Resident sitting on floor. CNT stated was assisting resident to BR (bathroom) and resident lost...balance. CNT lowered resident to floor without injury..."

Medical record review of a Post Fall Evaluation dated March 9, 2011, revealed "...Summary of Interdisciplinary Team: Re-educate staff to apply gait belt for all transfers..."

Medical record review of a nursing note dated April 30, 2011, at 1:20 a.m., revealed "Res (resident) found on floor @ bathroom door...bathroom door alarm did not sound, had to change batteries, no apparent injuries..."

Observation on July 25, 2011, at 12:02 p.m., revealed the resident seated in a wheelchair, with a pressure pad alarm in place, in the resident's room.

Interview on July 26, 2011, at 9:15 a.m., with Licensed Practical Nurse (LPN) #2, (nurse who signed the Post Fall Evaluation dated March 9, 2011) at the nursing station, confirmed the gait belt was not in place or used at the time of the resident's fall on March 9, 2011.

Interview on July 26, 2011, at 9:00 a.m., with the Director of Nursing, at the nursing station, confirmed the batteries to the bathroom door alarm were dead, and the bathroom door alarm

F 323

The ID Team, consisting of Director of Nursing, Assistant Director of Nursing, Staff Development Director, Unit Coordinator, MDS Coordinator and Social Services Director to audit 10% of in house residents with fall preventions of gait belts and door alarms monthly X 3 months, then quarterly to ensure compliance.

The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).

The Administrator is responsible for overall compliance.

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NAME OF PROVIDER OR SUPPLIER SMITH COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 112 HEALTH CARE DR CARTHAGE, TN 37030	
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F 323	Continued From page 10 did not sound at the time of the resident's fall on April 30, 2011.	F 323		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide assistance and assistive devices to maintain independence while eating for one resident (#26) of twenty-nine residents reviewed. The findings included: Resident #26 was admitted to the facility on December 16, 2009, with diagnoses including Subdural Hematoma, Type II Diabetes Mellitus, and Renal Failure. Medical record review of the Minimum Data Set dated July 12, 2011, revealed the resident had impaired long and short term memory, severely impaired decision-making skills, required total assistance for transfers and movement throughout the facility, was independent eating with set-up help, and had no weight loss. Medical record review of the Medical Nutritional Therapy Review dated July 13, 2011, revealed the resident was independent with dining skills and required a Plate Guard (device placed on an edge of the plate to assist scooping food onto utensils).	F 369	F369 It is the practice of this facility to Provide special eating equipment and utensils. Resident #26 sustained no adverse affects from this deficient practice. All residents with a need for special eating equipment and utensils have the potential to be affected by this deficient practice. Resident #26 was provided with a new tray and a new plate guard attached. Liquids were placed with in reach and resident monitored to ensure ability to reach liquids. Resident was repositioned at the table to allow for better reach. (07/27/11) Therapy screened for assistive devices. (07/27/11) ID Team consisting of Director of nursing, Assistant Director of Nursing, Staff Development Director, Unit Coordinator, MDS Coordinator and Social Services Director to audit all in house residents medical records to identify residents requiring assistive devices for meals to ensure proper placement and usage of devices. (09/09/11) Staff Development Coordinator to inservice Licensed Nurses and CNT's to use of feeding devices, proper meal set up and proper placement at tables by residents during meals. (09/09/11) DON and/or ADON to audit residents with feeding devices monthly X 3 months then quarterly to ensure proper usage, placement at table and meal set up.	09/09/11

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F 369	Continued From page 11 Observation on July 27, 2011, from 8:00 to 8:10 a.m., in the dining room, revealed the resident was sitting in a chair at a table with a breakfast plate, glass of milk, glass of orange juice, and cup of coffee. Observation revealed the resident was attempting to scoop food onto a fork and was pushing the food off the plate, with no plate guard present on the plate. Observation revealed the milk and orange juice were placed above the plate, out of reach of the resident, and the resident used the fork to attempt to reach the orange juice and move it into reach, unsuccessfully. Observation revealed two staff members present in the dining room walked near the resident and did not assist the resident or check to see if the resident needed assistance. Interview and observation with the Director of Nursing and the Staff Development Coordinator on July 27, 2011, at 8:10 a.m., in the dining room, confirmed the milk and orange juice had been placed where the resident could not reach them, and when placed in reach, the resident grabbed each glass and began drinking independently. Interview confirmed the resident had a history of removing the plate guard, which staff had not replaced, and the beverages had been placed out of the resident's reach.	F 369	Results to be reported to Performance Committee monthly to ensure compliance. The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s). The Administrator is responsible for overall compliance.		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 Individual residents not identified on the HCFA-2567. The nature of the deficiency prohibits identification of affected resident. Finding #1 The dish machine malfunction required repair by the serving company. The machine was repaired 07/25/11.	09/09/11	

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F 371	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of the manufacturer's recommendation for dish machine wash temperature, and interview, the facility dietary department failed to wash dishes at 160 degrees Fahrenheit per the manufacturer's recommendation; failed to maintain a sanitary dishroom environment; failed to maintain sanitary equipment; and failed to remove expired dairy products from storage.</p> <p>The findings included:</p> <p>Observation on July 25, 2011, beginning at 8:54 a.m., with the Certified Dietary Manager present, revealed twelve dish racks processed through the dish machine. Further observation revealed the wash temperature ranged from 152 to 154 degrees Fahrenheit (F). Further observation revealed one rack of plastic bowls and two racks of trays were dried and stored.</p> <p>Review of the manufacturer's recommendation posted onto the dish machine revealed the recommendation of 160 degrees F minimum for the wash cycle.</p> <p>Interview with the Certified Dietary Manager, on July 25, 2011, at 8:59 a.m., confirmed the dish machine wash cycle was not 160 degrees F as recommended by the manufacturer.</p>	F 371	<p>The Dietary employee who processed the dish racks through the dish machine was counseled 08/03/11 by the Dietary Manager. Dietary employees were instructed via inservice by the RD and Dietary Manager on dish washing machine temperatures, procedures on what to do if water temperatures are below required temperature. 08/04/11.</p> <p>Temperature of the dish machine is recorded after each meal.</p> <p>The Dietary Services Manager/Cook will review the dish machine testing for compliance by random testing 3X weekly with results to be reported to Performance Improvement Committee monthly X3 to ensure compliance.</p> <p>The Finding #2 wall mounted fan was removed and no longer blows air directly onto the dirty dishes. 08/03/11.</p> <p>Finding #3 can opener base was dirty; this was corrected on 07/25/11.</p> <p>The Dietary Manager has developed and implemented a cleaning schedule to address areas identified. 08/12/11</p> <p>Finding #4 Expired container of cottage cheese. Corrected as container was discarded 07/24/11.</p> <p>The Dietary Manager and Cook inspected the remaining containers of cottage cheese. And remaining items in the refrigerator. The Registered Dietitian conducted inservice for the Dietary employees on checking for out of date foods, date and label all food in the refrigerator. 08/12/11</p> <p>Monitoring by the Dietary Manager.</p>		

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F 371	Continued From page 13 Observation on July 25, 2011, at 8:54 a.m., and July 26, 2011, at 7:55 a.m., revealed a wall mounted fan on the dirty side of the dish machine was blowing directly onto the dirty dishes at the dish machine. Interview with the Certified Dietary Manager, on July 25, 2011, at 8:59 a.m., and July 26, 2011, at 7:55 a.m., confirmed the wall mounted fan was blowing directly onto the dirty dishes at the dish machine. Observation on July 25, 2011, beginning at 9:05 a.m., with the Supervisor of Nutritional Services present, revealed a can opener with sticky, blackened debris in the slot and blade contact area. Observation of the walk-in refrigerator revealed one full five pound container of cottage cheese and one five pound container that was 1/8 full of pureed cottage cheese, with the expiration date of July 24, 2011, was stored with four other containers of cottage cheese with expiration dates of August 6 and 13, 2011. Interview with the Supervisor of Nutritional Services, on July 25, 2011, at 9:05 a.m., confirmed the can opener slot and blade contact area had sticky, blackened debris present. Further interview confirmed the two containers of cottage cheese had expired on July 24, 2011, and was stored with other containers of cottage cheese.	F 371	The Dietary Services Manager will conduct a random inspection of the Dietary Department weekly for 3 months, monthly thereafter for a total of 1 year with results to be reported to Performance Improvement Committee monthly to ensure compliance. The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s). The Administrator is responsible for overall compliance.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441			

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F 441	<p>Continued From page 14</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441	<p>F441</p> <p>Resident found to be affected by the deficient practice was identified as resident #3. No harm to this resident has been noticed. Facility will ensure appropriate infection control practices are followed during wound care for resident #3.</p> <p>Residents who have the potential to be affected by this deficient practice would any resident using/receiving dressing changing. The facility will ensure appropriate infection control practices are followed during wound care for any resident with the potential to be affected by this deficit practice.</p> <p>The facility will ensure appropriate infection control practices are followed by inservicing the Physical Therapy staff on Infection Control, proper gloving, hand washing. This education will be complete by the Staff Development Coordinator (SDC) and/or Director of Therapy by 09/09/11.</p> <p>Therapy staff will receive competency testing on Infection Control procedures: proper gloving, hand washing by the SDC and/or Director of Therapy by 09/09/11. Infection Control Procedures will be monitored by the DON, ADON, SDC and/or Director of Therapy weekly x 1 month until no further deficit practice is found. Discrepancies will be reported to the Infection Control Nurse and to the DON. Personnel will be retrained if required by the SDC or DON and/or Director of Therapy. Discrepancies will be reported to the Center PI (QA) Committee by the DON.</p>	09/09/11	

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F 441	<p>Continued From page 15</p> <p>Based on observation, facility policy review, and interview, the facility failed to follow appropriate infection control practices during wound care for one (#3) of twenty-eight residents reviewed.</p> <p>The findings included:</p> <p>Medical record review revealed resident #3 was admitted to the facility on March 25, 2011, with diagnoses to include Hypertension, Diabetes Mellitus, Dementia, Sacral Pressure Ulcers, and End-Stage Renal Disease.</p> <p>Observation of the wound care to the sacral pressure ulcer on July 26, 2011, at 8:30 a.m., revealed an ulcer measuring 7 cm (centimeters) x 4.5 cm x 3 cm with black eschar in the wound bed. Observation of the procedure revealed the Physical Therapist changed gloves seven times during the procedure and only washed hands once after removing soiled gloves and before donning clean gloves. Continued observation revealed the Physical Therapist also did not sanitize the hands when gloves were removed before new gloves were donned.</p> <p>Review of facility policy entitled "Infection Control Work Practices" revealed the statement "Employees wash their hands with soap and water immediately or as soon as feasible after removal of gloves or other personal protective equipment".</p> <p>Interview on July 27, 2011, at 3:10 p.m., in the conference room, the Rehabilitation Coordinator confirmed hands are to be washed after gloves are removed.</p>	F 441	<p>The Committee will review reports, make recommendations and instruct/give direction to assure compliance</p> <p>Reporting to the PI committee will be accomplished/repeated each 30 days for a minimum of 90 days and/or until zero error reported.</p> <p>The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).</p> <p>The Administrator is responsible for overall compliance.</p>		
F 502	483.75(j)(1) ADMINISTRATION	F 502			

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F 502 SS=D	<p>Continued From page 16</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain laboratory services as ordered by the physician, for one (#11) of twenty-nine residents reviewed.</p> <p>The findings included:</p> <p>Resident #11 was admitted to the facility on July 12, 2011, with diagnoses including Atrial Flutter, Pneumonia, Congestive Heart Failure, and Hypertension.</p> <p>Medical record review of the physician's orders dated July 12, 2011, revealed the resident was to receive warfarin (Coumadin/anticoagulant) 5 mg (milligrams) starting on July 14, 2011, after obtaining a PT/INR (laboratory test for blood coagulation), and to obtain a PT/INR on July 14, 2011, and then obtain a weekly PT/INR.</p> <p>Medical record review of a laboratory report dated July 14, 2011, revealed PT-16.1 (reference range 8.9-11.9) and INR-1.59 (reference range 2.0-3.0).</p> <p>Medical record review of a physician's order dated July 18, 2011, revealed "Change PT/INR weekly to PT/INR 3 times a week Mon-Wed-Fri x (times) one week-then go back to checking weekly."</p>	F 502	<p>F502</p> <p>The Center does provide laboratory services to meet the needs of its residents.</p> <p>Resident #11-.Lab work has been completed As ordered 07/25/11. The resident #11 had no adverse effects of the delay in obtaining results.</p> <p>All residents with a Lab Order for PT/INR have the potential to be affected by this deficient practice</p> <p>ID Team consisting of Director of Nursing, Assistant Director of Nursing, Staff Development Director, Unit Coordinator, MDS Coordinator and Social Services Director will audit the medical records of all in house residents, who are receiving Coumadin and have T/INR orders. (09/09/11)</p> <p>Director of Nursing to council Nurse who failed to obtain PT/INR. (09/09/11) Nurse will also attend inservice on Lab order processing PT/INR.</p> <p>DON and or SDC to in service Licensed Nurses to processing PT/INR orders. (09/09/11)</p> <p>Monitoring by the ADON or Nursing Supervisor to review PT/INR labs daily to ensure completion.</p> <p>The ADNS will present the results of the lab work audits to the P.I. Committee monthly for review and action, as indicated.</p>	09/09/11	

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F 502	<p>Continued From page 17</p> <p>Medical record review of a laboratory report dated July 20, 2011, (Wednesday) revealed PT-23.7 and INR-2.34.</p> <p>Medical record review revealed no documentation the PT/INR was completed on July 22, 2011 (Friday).</p> <p>Medical record review of a physician's order dated July 25, 2011, revealed PT/INR to be drawn stat (right now).</p> <p>Medical record review of a laboratory report dated July 25, 2011, revealed PT-39.3 and INR-3.90.</p> <p>Medical record review of a physician's order dated July 25, 2011, revealed "Hold 5 mg Coumadin dose on 7-26-11. On Wednesdays and Sundays give 2.5 mg Coumadin. Continue weekly PT/INR lab draws. Next draw 8-1-11."</p> <p>Interview on July 26, 2011, at 8:00 a.m., with the Director of Nursing, at the nursing station, confirmed the PT/INR was not completed as ordered on July 22, 2011.</p>	F 502	<p>The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).</p> <p>The Administrator is responsible for overall compliance.</p>		